

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>PORTER REGIONAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 EAST US HWY 6 VALPARAISO, IN 46383</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00153358</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 4/22/15</p> <p>Facility Number: 005033</p> <p>Porter Regional Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 05/13/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE